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### Fatigue and multiple sclerosis: Experience of a therapeutic education seminar

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**Keywords:** Multiple sclerosis; Fatigue; Therapeutic education

**Background.**— Fatigue is a common and disabling symptom in multiple sclerosis. The objective of this work was to study the impact of a therapeutic education program on fatigue management and its effect on quality of life.

**Methods.**— One-day seminar, divided into several workshops on the topic of fatigue. Evaluation at 3 months of the impact on quality of life. Inclusion criteria: people with multiple sclerosis, evolving for more than a year and less than 10 years, complaining of fatigue as most incapacitating symptom with a maximum EDSS score of 3.5.

**Results.**— Sixteen patients benefited from this program, at 3 months there was a non significant decrease in the score of the EMIF scale, and an improvement of quality of life on the SF36 scale, with a significant gain on the item vitality.

**Discussion.**— This work highlights the importance of therapeutic education program in the field of fatigue and more broadly on disability in multiple sclerosis. Patients were able to develop coping strategies in everyday life, allowing them to limit the consequences of neurological impairment.

**Conclusion.**— Therapeutic education can improve the quality of life of patients suffering from multiple sclerosis especially in the field of fatigue management.

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### Fampyra effect on spasticity and fatigue in multiple sclerosis

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**Keywords:** Fampridine; Multiple sclerosis; Fatigue; Spasticity

**Objective.**— Fampyra effect on spasticity and fatigue in multiple sclerosis.

**Methods.**— This is a retrospective study of prospectively collected data on patients with multiple sclerosis. Effectiveness was tracked after 14 days of treatment using the T25FWT as an objective measure of walking speed. Fatigue was measured with the EMIF-SEP questionnaire and spasticity with a validated 0–10 Numerical Rating Scale (NRS).

**Results.**— Hundred and forty-six patients were recruited between April 2013 and October 2013. Hundred and thirty-five patients (age:  $54 \pm 18$ , 6; EDSS median: 6) were evaluated: T25FWT decreased significantly ( $P < 0.0001$ ). EMIF-SEP overall score decreased significantly ( $P < 0.0001$ ) and all dimensions of it ( $P < 0.0001$ ). NRS score decreased significantly ( $-28\%$ ;  $P < 0.0001$ ).

**Conclusion.**— Dalfampridine has a positive effect on walking ability [1], spasticity [1] and fatigue.

**Reference**

[1] Goodman AD, Brown TR, Cohen JA, et al. A phase 3 trial of extended release oral dalfampridine in multiple sclerosis. *Ann Neurol* 2010;68:494–502.

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### Energy expenditure comparison between multiple sclerosis patients and healthy subjects during simple daily gestures

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**Keywords:** Multiple sclerosis; Energy expenditure; Autonomy at home

**Objective.**— The aim of this study is to measure the impact of multiple sclerosis (MS) on energy expenditure (EE) during daily tasks in a kitchen.

**Methods.**— Nine SEP patients (SEPG) and nine healthy subjects (CG) have participated in this study. The EE ( $\text{kJ.kg}^{-1}$ ) has been determined by an indirect calorimetry analysis (K4b2) during three pathways each comprising: carrying loads, opening/closing of drawers and round trips in the kitchen.

**Results.**— The average EE values by pathway was  $5.15 \pm 1.5$  (P1),  $4.32 \pm 1.5$  (P2) and  $4.23 \pm 1.2$  (P3)  $\text{kJ.kg}^{-1}$  for SEPG and  $4.58 \pm 2.6$  (P1),  $4.45 \pm 2.5$  (P2) and  $4.38 \pm 2.7$  (P3)  $\text{kJ.kg}^{-1}$  for CG. The two-way Anova for repeated measures (SEPG-CG vs P1-P2-P3) showed a pathway effect ( $F_{[2,16]} = 4.6$ ,  $P = 0.03$ ) but no group effect ( $F_{[1,8]} = 0.02$ ,  $P > 0.05$ ). A significant decrease between P1 and P3 was observed in SEPG ( $P = 0.04$ ) but not for CG ( $P > 0.05$ ).

**Discussion.**— The higher energy cost at the beginning than at the end of the protocol for GSEP seems to be due to the habituation of the tasks. The gesture economy in GSEP could be achieved through learning.

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### Health networks and multiple sclerosis: An update

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If, as described by Naiditch, a network consists of a set of actors staging process for which they are accountable, creating health networks, including those dedicated to multiple sclerosis, enrolled in health policy in France. Ordinances of 24 April 1996, called Ordinances Juppé, aimed to mobilize the health, social and other resources around the needs of the territory, to provide better referrals, promote coordination and continuity of care, promote the quality of local health care delivery. Thus, the creation of networks, more or less experimental, coming “from above” to get a force of law. Thereafter, various methods have framed the creation of networks: the Improvement Fund to Quality Care in the City (12 November 1999) and the National Endowment for the Development of Networks (21 December 2001) and the base of Intervention for Quality and Care Coordination (1 July 2007).

What are the current networks' successes or gaps? If they were created on a close model, what are the specificity of MS networks covering the national territory, what are their differences and their possible links? What is the future of networks and of which ones?

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### Alliance: National survey of the multidisciplinary management of patients with multiple sclerosis

